

# 19<sup>th</sup> NATIONAL CONFERENCE ON CHRONIC DISEASE PREVENTION AND CONTROL

## Exhibitor Agreement

Please complete this form to exhibit at the 19<sup>th</sup> National Conference on Chronic Disease Prevention and Control, March 1–3, 2005, at the Atlanta Marriott Marquis Hotel in Atlanta, Georgia. The deadline for exhibit booth reservations is January 28, 2005; however, exhibitors are encouraged to apply as soon as possible to ensure space availability.

*Be sure to book your booth early to secure the best location. (Name badges must be worn at all times)*

Organization/Company: \_\_\_\_\_

Division/Program: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Web site: \_\_\_\_\_

Special Booth Needs/Request: \_\_\_\_\_

Names of exhibit personnel: \_\_\_\_\_ 1)

(Only two included per booth)

\_\_\_\_\_ 2)

**BOOTH DESCRIPTION** Please provide a three-sentence description of your organization/company on lines provided or on a separate sheet of paper. Please note that this information will appear in the Exhibitor Directory that will be provided to all conference participants. Please email your organization's logo to [Conference@ChronicDisease.org](mailto:Conference@ChronicDisease.org).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I request \_\_\_\_\_ Non-profit/government booth(s) (8' x 10') at \$800 each.

I request \_\_\_\_\_ Private/commercial booth(s) (8' x 10') at \$1,600 each.

Total due: \$ \_\_\_\_\_

**ASSIGNMENT OF SPACE** All conference sponsors receive first priority on booth space. Additional assignments will be made based on when the signed exhibitor agreement was received by CDD. Show management reserves the right to make the final determination of all space assignments in the best interest of the 19<sup>th</sup> National Conference on Chronic Disease Prevention and Control.

**PAYMENT INFORMATION** Register by Check, Credit Card, or Purchase Order (PLEASE PRINT)

Purchase Order: PO #: \_\_\_\_\_

Check Enclosed \_\_\_\_\_

Credit Card

☐ Visa

☐ MasterCard

☐ Amex

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Name of Cardholder: \_\_\_\_\_

Official Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Amount: \$ \_\_\_\_\_

Federal Tax ID Number: 73-1328414



**Prevention  
Research  
Centers  
Program**

### Questions about exhibiting?

Jayne Washam

Meetings Manager

PHONE: 703-610-0265

FAX: 703-610-9005

EMAIL: [JWasham@ChronicDisease.org](mailto:JWasham@ChronicDisease.org)

### Please fax or mail your completed form to:

Chronic Disease Directors  
8201 Greensboro Dr., Suite 300  
McLean, Virginia 22102  
FAX: 703-610-9005

### For general conference inquiries please contact:

PHONE: 703-610-9000

EMAIL: [Conference@ChronicDisease.org](mailto:Conference@ChronicDisease.org)

POs will be accepted; however, registration will not be processed until the payment is received. Please submit PO "to be paid automatically without invoicing" when possible.